At-A-Glance: Comparing the 2010 PPO, EPO, and CDHP Medical Programs

Medical Program Benefit Comparison	PPO Benefits & Cost-Sharing		CDHP + HRA Benefits & Cost-Sharing		EPO Benefits & Cost-Sharing
	Preferred Provider (In-Network)	Nonpreferred Provider (Out-of-Network)	Preferred Provider (In-Network)	Nonpreferred Provider (Out-of-Network)	Preferred Provider (Only limited coverage for out-of-network care)
Calendar Year Deductible - All services are subject to deductible unless otherwise indicated below.	$250 Individual $750 Family	$500 Individual $1500 Family	$1500/Individual $2250/Employee + Adult OR $2250/Employee + Child(ren) $3000/Family		$150 Individual $450 Family
	Family deductible is an aggregate of **three** times the Individual amount. **PPO and non-PPO deductibles do NOT cross-apply.**		Family deductible is an aggregate of **two** times the Individual amount. **There is a single, shared PPO and non-PPO deductible.**		Family deductible is an aggregate of **three** times the Individual amount.
Calendar Year Out-of-Pocket Limit - Does **not** include penalty amounts, if any, noncovered charges, or amounts over the covered charge. Under the PPO and CDHP programs, the PPO and non-PPO amounts do **not** cross-apply. After a member (or family) reaches the applicable out-of-pocket limit, the Medical Program pays 100 percent of most of that member's (or family's) covered charges for the rest of the year.	$3,000 Individual $9,000 Family	$6,000 Individual $18,000 Family	Individual - $2,750 Employee + Adult - $4,125 Employee + Child(ren) - $4,125 Family - $5,500	Individual - $8,500 Employee + Adult - $12,750 Employee + Child(ren) - $12,750 Family - $17,000	$2,000 Individual $6,000 Family
	The following items apply to your out-of-pocket limit - deductible, copayments, and percentage coinsurance. The following items do not apply to your out-of-pocket limit - out-of-network inpatient hospital copayment, residential treatment center copayment, and drug plan copayments.		The following items apply to your out-of-pocket limit - percentage coinsurance and amounts paid by you under the drug plan. The following items do not apply to your out-of-pocket limit - deductible or the residential treatment center copayment.		The following items apply to your out-of-pocket limit - deductible, copayments, and coinsurance. The following items do not apply to your out-of-pocket limit - residential treatment center copayment and drug plan copayments.
Health Reimbursement Account (HRA) - Used to offset the CDHP Medical Program deductible, copayments, and coinsurance. Up to a three-year cap on rolled over dollars. Funds may also be used to offset certain expenses not covered under the Medical Program.	N/A		Employee Only - $750 per calendar year Employee + Adult - $1125 per calendar year Employee + Child(ren) - $1125 per calendar year Family - $1500 per calendar year		N/A
Lifetime Maximum Benefit Limit (per member)	Unlimited	**$2,000,000**	Unlimited	**$2,000,000**	Unlimited
BASIC HOSPITAL AND PHYSICIAN SERVICES					
Office Visit/Exam Charge (Nonroutine)	$20/visit *(deductible waived)*	40% after deductible	10% after deductible	40% after deductible	$20/visit *(deductible waived)*
Therapeutic injections and diagnostic tests; Office surgery and supplies; Allergy care; Family planning surgery and injections	10% after deductible	40% after deductible	10% after deductible	40% after deductible	10% after deductible
Routine/Preventive Care (Includes exams, physicals, checkups, lab tests, immunizations, colonoscopies, etc.)					
Well-Baby (Through Age 2)	No Copay (*deductible waived*)	40% (*deductible waived*)	No Copay (*deductible waived*)	40% (*deductible waived*)	No Copay (*deductible waived*)
Well-Child (Ages 3-18) *Adult Physicals and Colonoscopies (Ages 19 and Older)*	$20/visit *(deductible waived)*	40% after deductible	No Copay (*deductible waived*)	40% after deductible	$20/visit *(deductible waived)*
Lab, X-Ray, and Other Testing	No Copay (*deductible waived*)	40% after deductible	No Copay (*deductible waived*)	40% after deductible	No Copay (*deductible waived*)
Inpatient Hospital Charges/Inpatient Surgery *Inpatient Physician Medical Visits/Consultations* *Inpatient OB/Gyn Maternity Delivery Global Fee*	10% after deductible No Copay (*deductible waived*) No Copay (*deductible waived*)	$250 + 40% after deductible 40% after deductible 40% after deductible	10% after deductible No Copay (*deductible waived*) 10% after deductible	40% after deductible	10% after deductible No Copay (*deductible waived*) No Copay (*deductible waived*)

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Outpatient Hospital/Ambulatory Surgery Center	10% after deductible	40% after deductible	10% after deductible	40% after deductible	10% after deductible
Emergency Room Visit (*emergency* condition only)	$75/visit (deductible waived)		10% after PPO deductible		$75/visit (deductible waived)
Physician and Other Professional Provider Charges	10% after PPO deductible		10% after PPO deductible		10% after deductible
Independent Lab/X-Ray Facility	10% after deductible	40% after deductible	10% after deductible	40% after deductible	10% after deductible
Urgent Care Facility	$20/visit *(deductible waived)*	40% after deductible	10% after deductible	40% after deductible	$20/visit *(deductible waived)*
- Ancillary Services (lab tests, x-rays, supplies, etc.)	10% after deductible	40% after deductible	10% after deductible	40% after deductible	10% after deductible
Hospice Care (Lifetime benefit limited to **$7,400**; respite care limited to **10 days** for every 6-month period; bereavement counseling must be provided by the hospice as part of overall cost.)	10% *(deductible waived)*	40% *(deductible waived)*	10% after deductible	40% after deductible	10% *(deductible waived)*
Short-Term Rehabilitation, Outpatient and Office (Includes physical, occupational, and speech therapy.) **Acupuncture/Spinal Manipulation** (Each therapy limited to **20 visits**/calendar year.)	$20/visit *(deductible waived)*	40% after deductible	10% after deductible	40% after deductible	$20/visit *(deductible waived)*
Office Chemotherapy/Radiation Therapy	$20/visit *(deductible waived)*	40% after deductible	10% after deductible	40% after deductible	$20/visit *(deductible waived)*
Mental Health/Chemical Dependency - Office, Outpatient, Intensive Outpatient Programs (IOP) - Outpatient Suboxone Treatment - Inpatient and/or Partial Hospitalization - Related Inpatient Physician Claims - Residential Treatment Center (For chemical dependency only; max. **130 days**/lifetime), including physician	 $20/visit *(deductible waived)* 10% after deductible 10% after deductible No Copay (*deductible waived)* $250 facility copay plus 20% after deductible	 40% after deductible 40% after deductible $250 + 40% after deductible 40% after deductible $250 copay plus 40% after deductible	 10% after deductible 10% after deductible 10% after deductible No Copay (*deductible waived)* $250 facility copay plus 20% after deductible	 40% after deductible 40% after deductible 40% after deductible 40% after deductible $250 facility copay plus 40% after deductible	 $20/visit *(deductible waived)* 10% after deductible 10% after deductible No Copay (*deductible waived)* $250 facility copay plus 20% after deductible
● PRESCRIPTION DRUGS, INSULIN, SPECIFIED VACCINES, DIABETIC SUPPLIES, ENTERAL NUTRITION, SPECIAL MEDICAL FOODS					
Retail Pharmacy/Specialty Pharmacy Programs (Up to a 30-day supply or 180 units, whichever is less. Some drugs require prior approval before coverage will be available. Benefits include flu, pneumococcal, and Zostavax vaccines for which no copayment is required.)	$15/generic; $30/brand-name drug on Drug List; $45/brand-name drug not on Drug List and for special medical foods/enteral nutrition*		You pay 20% of covered charges after the deductible is met.*		$15/generic; $30/brand-name drug on Drug List; $45/brand-name drug not on Drug List and for special medical foods/enteral nutrition*
Mail-Order Program (Up to a 90-day supply or 540 units, whichever is less.)	Two copayments as listed above*				Two copayments as listed above*
*If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost plus the generic drug copayment. You must use a participating pharmacy.	Charges payable under the drug plan are not subject to the medical plan deductible or out-of-pocket limit provisions.		Deductible and out-of-pocket limit provisions apply to charges payable under the drug plan.		Charges payable under the drug plan are not subject to the medical plan deductible or out-of-pocket limit provisions.

This document is a basic comparison of the non-Medicare LANS medical programs for 2010. It is not a complete overview and additional exclusions and limitations will apply. This document highlights the major differences among the programs in order to assist you with making a decision about which program best suits your and your family's health care needs.